The Steady and Successful Climb of BAROnova: Interview with Hugh Narciso

Henry Ford is famous for stating, “If I had asked people what they wanted, I would have built a faster horse.” Although it’s arguable whether he ever uttered those words, the statement is still very powerful.

And it’s one that Hugh Narciso has taken to heart. In fact, in the early days of BAROnova, when Hugh and his team were getting feedback from KOL’s, they utilized this framework to help propel their device forward.

In the following interview with Hugh Narciso, Founder and CEO of BAROnova, learn more about the strategies and tactics his team employed throughout BAROnova’s steady and successful climb over the past 10 years.

Scott Nelson: You founded founded BAROnova back in 2006. It's now early 2016, a full 10 years later. That’s a long time from anyone’s perspective. How are you feeling about your position now? Especially against entrenched incumbents like Allergan with the LAP-BAND procedure as well as other startups that are in the same space like GI Dynamics and EnteroMedics.

Hugh Narciso: Well, we're pretty happy about where we are as a company. Like you said, we founded the company in 2006 and we've accomplished quite a bit. We've been through a couple of human clinical trials including our most recent one which we conducted in Sydney, Australia. Now, in that trial, we demonstrated a significant level of weight loss in those patients. Just to give you an example, at the six-month time point, the average weight loss for our patients who had BMIs between 30 and 40 was about 14.9% total body weight loss. So if you take the weight of the patient and you subtract about 15% of their weight, that's what they achieved in six months. And if you look at comparable obesity trials that’s a pretty large number. So we're very happy where we are with our clinical results. We're continuing to develop the product – the Transpyloric Shuttle is the name of our device. And compared to companies like Reshape, Apollo, GI Dynamics, EnteroMedics, those guys are all trailblazers and they’ve set the standard with their regulatory approvals. We appreciate all that they’ve done for the space of obesity and we're just going to follow in their wake and hopefully have a successful pivotal trial, and then we look

forward to competing with them in the market once we get the necessary approvals.

Scott Nelson: You mentioned a couple of the things that I want to discuss, the trial in Australia as well as your pivotal trial that you're starting in the U.S. But let's start with the actual device. You mentioned it's often referred to as the TPS device. Give us a high-level overview of the device as well as the disease that you're aiming to treat. And then how it compares to other devices that physicians would use in today's market.

Hugh Narciso: The TPS is an endoscopic device. That means there's no surgery required to deliver or retrieve the device. So it's a completely endoscopic procedure relative to delivery and retrieval. And what we demonstrated in that Australian study was that the level of weight loss that I previously referred to was actually superior to the weight loss that you see in a similar study conducted by Allergan when they did their low BMI trial. Now, your audience may or may not know, but the LAP-BAND is a surgical procedure, so there's surgery involved in that procedure. Since there's no surgery involved in our procedure, you can get surgical levels of weight loss without the need for surgery. So we think we've got a pretty good competitive advantage once we get to market with our device.

This device that we deliver endoscopically, we in effect, build it in your stomach. So we send it down in a deconstructed fashion and then, by engaging a few levers and pulleys in the delivery system, we're able to construct it in the stomach. And what you end up with is a ball, probably a little bit smaller than a tennis ball with a tail on the end of it. In terms of function, because of its shape and its size, that tail wants to go across the outflow of the stomach, which is the pylorus. So it crosses that valve and the tail sits in the intestine, the duodenum, and the ball will fit in the stomach.

And so our device was designed to work in concert with your own physiology. A lot of technologies try to fight physiology. Ours was designed to work with your physiology. There's something called peristalsis, which is a series of contractions and relaxations of muscle that forces food from the stomach into the intestine and then down the intestinal tract. When that wave, which starts at the top of the stomach, starts to squeeze down on the stomach, it'll actually push our device down into the outflow of the stomach, the pylorus, and it'll intermittently block that valve. So the way it pushes our device into place and when the wave passes over our device, it'll pop it out. It pops up a little bit out of

the pylorus, kind of a watermelon seed will pop when you squeeze it between your fingers. So once that device pops up, it allows food to pass around it, and then the next wave comes along and pushes our device back in place.

So it's your body's natural physiology, peristalsis, which creates the shuttling motion of our device and that's why we call it a transpyloric shuttle. And by shuttling back and forth, we intermittently block the outflow of your stomach so the patient will fill up quicker and stay full longer. And it's really that simple. That's the mechanism that we think we're operating under.

Scott Nelson: And you said it's sort of constructed in place. So am I right in saying the parts are delivered through an endoscope and then the physician would actually build it sort of in place within the stomach?

Hugh Narciso: They're not delivered through the endoscope—the endoscope is there to visualize the process at various points in the delivery procedure. But we've got our own catheter that is delivered through the mouth down the esophagus and into the stomach. And like I alluded to earlier, by turning a couple of cranks, what you end up doing is you engage some strings which then engage some locks and ultimately you lock the device in place. And by locking it, that's what I call constructing the device in your stomach.

Scott Nelson: This next question actually came from the Medsider audience, Ted Jordan with Stellar Technologies. How does the physician then remove the implant after the patient loses the desired amount of weight?

Hugh Narciso: It's an endoscopic procedure, so there's no surgery involved in either aspect, delivery or retrieval, of our product. So the physician would go down with a normal endoscope, and typically endoscopes have working channels, so we use devices that go through those channels that are well-known to gastroenterologists and surgical endoscopists. Things like snares or graspers. And they will put a grasper down the central channel of the scope and the scope allows you to visualize where the device is. And right on the top of that ball that I described earlier, there's a release mechanism. So you grab onto that release mechanism, pull that back up against the overtube and apply a little pressure, and it releases all four locks of the device. And once the locks are released, the device can be deconstructed and the silicone is then pulled out through the overtube.

Scott Nelson: It sounds very familiar to an IVC filter removal and maybe that's because I've spent most of my career in the vascular space. But that concept of

grasping onto a hook and retrieving the implant out of a vessel, or in this case the stomach, sounds fairly familiar.

Hugh Narciso: Correct.

Scott Nelson: Let's now go back to pre-2006 before you founded the company. You spent time with some other startups Miravant Medical, Corvascular, Leptos Biomedical. When you think about your early experiences, are there some mentors that you learned quite a bit from? Can you speak to some of the experiences that you learned along the way that would be helpful for the rest of us?

Hugh Narciso: Well, more than 10 years ago I had a lot less gray hairs, so I miss those days. But I've had the good fortune to work with some very knowledgeable and great mentors that really understand the medical device and pharma industries. I've spent some time doing both medtech and biotech and I've had the good fortune of being under the tutelage of people who are willing to allow me to expand my capabilities, but while also doing that, to instill the passion that's obviously required to succeed in any business. So I think a lot of it is luck. So like I said, I had the good fortune to work with people who took an interest in my career and allowed me to expand and learn from my mistakes and my successes.

Scott Nelson: Is there anything that you specifically did to foster those types of relationships?

Hugh Narciso: I always made it clear to my managers and my mentors that I enjoyed learning. And once I had gotten proficient in an area, I always wanted to take on more. So they were always willing to feed me as fast as I could take on new things so long as I could do it responsibly and successfully. It's really just kind of like pushing the envelope throughout your career. But you've got to have a passion for what you're doing. Have that passion and be willing to work the extra hours to accomplish what you need to accomplish and learn what you need to learn.

Scott Nelson: I'm making a hunch here, but I'm guessing your passion was probably contagious, which probably opened the doors to some of those relationships. So I'm glad you mentioned that because you've been at this with BAROnova for 10+ years. You've got to have a lot of passion for what you're doing in order to make that work. On that same sort of note, speaking of the early days of BAROnova, what drew you to the obesity market? Was it something in particular?

Hugh Narciso: Before we founded BAROnova, I had spent some time with Leptos Biomedical and Leptos was the company developing neural stem

technology to treat obesity. So that was my introduction to obesity and, obviously, everyone knows it's a very large market. It's probably, if not the biggest, one of the biggest medical opportunities that's out there and there are a lot of ways to attack it. And neural stem was one way to attack it.

But when my time was coming to a close at Leptos as they decided to relocate the company, I was approached by my cofounder in BAROnova, Dr. Dan Burnett. Dan is one of these serial entrepreneurs. Probably a better description is he's a parallel entrepreneur because he's probably got five, six or seven venture-backed companies that have started off or are in operation right now. And Dan had this concept that he had developed while he was still at Duke medical school for the Transpyloric Shuttle. His early prototyping was quite different from what we have in the clinic right now but the basic concept is still there. I thought it was a fantastic concept in that the simplicity of the approach is what makes it elegant. It's easy to tell people whether they're an investor or a doctor or a patient how this thing works. It basically works as a ball valve, an intermittent valve that we put in the outflow of your stomach that causes you to fill up quicker and stay full longer. So it's an easy story to tell, but it's an elegant device as well.

And when we took it into the clinic, what we discovered was that these patients lost a lot of weight. We knew we had something there when these early patients would lose a significant amount of weight without the need for surgery.

Scott Nelson: You kind of hinted at it earlier with respect to the fact that the first prototype looked a lot different than the device that was studied in your trial in Australia. Can you talk about how you went from initial prototype and how you iterated on that idea based on the feedback that you received in the market?

Hugh Narciso: Obesity is a challenging field. It's also a relatively new field. So it's not like cardiovascular disease where people have been not only developing products for cardiovascular disease, but they've been inventing animal models that will mimic what you see in the clinic. I think one of the major Achilles heel for obesity right now is there's no large animal model that is predictive of what you will see once you take your device from animal testing into the clinic. We can do all the testing, and we did do a series of bench-top and animal testing on our device, but you never really know how it's going to work until the rubber hits the road, or until you take it

into the human clinic. And what we learned in those early trials was that it's functioning as we designed it to function. So that's kind of the exciting point. There's the anticipation and then the nervousness about taking it into the clinic. You've done all you can to make sure it's a safe device, but now we've got to find out if it's going to be an efficacious device. So when we did that in our early trial and got the results that we got, we were excited. And that allowed us to attract an investor in our series B, which was Allergan, who at the time was the world leader in devices for weight loss and obesity.

Scott Nelson: And the series B, that was back in 2008, is that right?

Hugh Narciso: Correct.

Scott Nelson: At that point in time, was the LAP-BAND on the market?

Hugh Narciso: Yeah. The LAP-BAND had probably been on the market for about five years by that point.

Scott Nelson: Five years, okay. So the LAP-BAND was commercialized in the early 2000s, and then fast-forward to 2008, and Allergan becomes a strategic investor. Very good. So before we move on to sort of how you began to build our your team at BAROnova, is there a certain methodology that you typically utilize or a framework that you personally utilize when it comes to making device iterations based on the feedback that you see in animal labs or in actual human trials?

Hugh Narciso: Well, it's important to have a stable of key opinion leaders. So we've surrounded ourselves with some of the best. World-famous gastroenterologists and surgical endoscopists to help us with that process. Now, part of the problem is you can go to these KOLs and say, “What should we develop?” And if you're too broad when you approach these people, you're not going to get the answer that you're looking for because what they want to do is make a technology that they're familiar with. They want to make it a little bit better. And when we're talking about the TPS, we're talking about technology that is very different than everything else that's out there. So they don’t even know what’s possible until you show them what’s possible. And when we went down to them with the original concept of the TPS, the light bulb goes off in their head. And because they're very experienced clinicians they say, “Okay, well, you need to do A, B, C, and D,” and then we put our engineers in the room with the KOLs and hopefully some magic happens.

Scott Nelson: Maybe that's a piece of advice for other medtech entrepreneurs, or just other folks that serve in some sort of R&D capacity, that when you're

getting feedback from thought leaders or KOLs within a certain therapeutic arena, you need to go to them with a very specific sort of problem or a very specific need. Would that be accurate?

Hugh Narciso: Yeah. I don't know if you've ever heard the quote by Henry Ford, but he said that, "If I had listened to what the people wanted, I would have built a faster horse." So we didn't build a faster horse. Instead, to use that same analogy, we built the first car. So it was a very different concept, not just an improvement on something else that existed.

Scott Nelson: So let's fast-forward to your team now. So it's you and Dan in the early days of BAROnova. How quickly did you begin to build out a team and what did that look like?

Hugh Narciso: My philosophy throughout my career has always been to be capital-efficient. So we were capital-efficient before it was in vogue to be. You have to have some internal expertise because, like I said, the TPS was a new concept and we needed people inside the company that could develop that concept. You're never going to get the attention and the dedication that you need to develop a new product by outsourcing that. But that being said, I think a lot of the other peripheral activities within a company, especially early on, can be outsourced. There's enough excess capacity out there to get things done. And that allows you to use a certain function when you need it so you can avoid paying for it when you don't need it.

One example would be our manufacturing. When we took our series A dollars, we raised enough money to develop the product, test it on animals, and then do a handful of patients in our first-in-man trial. You probably need less than a hundred devices to support your clinical trial, to support your testing, and any other ancillary needs. Well, to build up a huge manufacturing facility in order to build a hundred devices that you're going to need over the next two years makes absolutely no sense. I could probably come up with another five or six examples of functions within an early company that you can outsource. I won't call it virtual because like I said, you do want that core competency. But it's like being semi-virtual.

Scott Nelson: Let's talk a little bit more about the regulatory environment as well as insurance coverage and reimbursement. Correct me if I'm wrong, but you probably agree that the FDA does tend to take a lot of criticism when it comes to slower regulatory times. You're dealing with a PMA device that's going to require even more regulatory scrutiny, not to mention the

fact that insurance coverage and reimbursement represents a whole new set of challenges. So when you think about positioning the TPS device for eventual commercialization in the US, what are you doing now to help you overcome some of those challenges.

Hugh Narciso: Let me start by agreeing with you. Over the 10 years that BAROnova's been around, there have definitely been headwinds and tailwinds from the FDA. So probably within the last, I don't know, three or four years, I would say that our group at the FDA has modified their way of thinking and they're very supportive to companies like BAROnova. I think a lot of that has to do with the leadership in the group that reviews our technology. It's Dr. Herb Lerner, who's done a phenomenal job with that group at the FDA. And I think they're using that as a model to extend to other areas of specialties.

But getting back to your question, I have established a relationship with Herb over the years and I have the ability to pick up the phone and give them a call and say, "Look, this is what's going on within our development area or within the clinic, and how can we work through this process?" So it's become a very iterative process and a very cooperative process with the FDA where if you had asked me this question six or seven years ago, I would have said the FDA is putting up barriers that are so high that even the approved devices that were out at the time couldn't be approved in that day.

So your point is well taken. With the regulatory environment, the pendulum consistently swings. And right now, it's swung to a cooperative direction. But getting an approval and not having reimbursement, or not addressing how people are going to pay for this technology is just as important. It's almost like you can't take one without the other. They're intricately intertwined. Because BAROnova is an endoscopic procedure performed on an outpatient basis, the cost of the device is relatively low compared to other technologies. So once we get our approval from the FDA, we believe the low cost of our device will support a self-pay market. It's probably similar to LASIK therapy. When LASIK first came out, it was something insurance wouldn't cover. But people would pay for it and practices would arrange for financing to support that approach. Now that being said, I think that's a short-term approach for us. Once we launch our device post-approval, I think there is incentive for the third-party payers to pick up the cost of our device and procedure if we can produce surgical levels of weight loss without the need for surgery. That's kind of code for we can get surgical levels of weight loss without all of the costs associated with surgery. I think the

third-party payers are going to be open to this approach. It's a dual track approach. While we're gaining reimbursement approvals, we will pursue a self-pay approach.

Scott Nelson: It seems like more and more medtech companies are keeping that self-pay option on the table. You can initially launch a device into a market and expect patients to pay for it, especially as copays and deductibles are continuing to increase. More and more patients are paying out of the pocket for some procedures. But on that note, even though you expect to launch into a self-pay market where patients are paying for this procedure with cash, are there activities that you're doing now to help with an eventual code, or more specifically, to help with coverage or reimbursement with third-party payers?

Hugh Narciso: Well, it's not that black and white. We've tried to have the discussion with third-party payers and it's really not a fruitful discussion until you're looking at data, right. We've just initiated our U.S. pivotal trial, which is a randomized, controlled, double-blinded trial. And so those data are going to be very pivotal in the assessment for third-party payers. But right now, we're establishing the relationships with our obesity society heads, because you really need to find people to carry your banner to the AMA to ultimately get the reimbursement codes that you're looking for. So right now the obesity societies are very aware of what we're doing. They're keeping an eye on what we're doing. We make sure we share our data with the societies so when it's time for them to pick up the banner and sing our song to the people that are responsible for coding I think we'll be prepared.

Scott Nelson: You recently raised your series D. Congrats on that. I think it was reported to be over $30 million, so very cool to see you guys do that. Before we get into what you're doing with the clinical trial here in the US, let's talk about your experiences with fundraising. I know your series B was back in 2008 and your series D was in late 2015. Are there some major lessons that you learned with respect to your early fundraising versus your late-stage fundraising? Also, you were able to raise money with both corporate entities as well private venture capital firms. I want to get your take on that too.

Hugh Narciso: I would say that series A and series B is more about the promise of the technology. I think series C and series D is more about execution. So by the time you get the series D and series E, you have to prove that you used the previous dollars raised in a responsible way, hopefully in an

efficient and effective way. At BAROnova, we've had the good fortune to be able to track many of the blue-chip healthcare venture groups to invest in us and we've also received investments both from Allergan, who at the time of the investment, was the world leader in medical devices for weight loss. Since then, they sold their obesity franchise to Apollo. And we've also revealed an investment from Boston Scientific. And, you know, Boston, while they're not actively involved in obesity, they've got a pretty mature endoscopic group where this white space technology could fit into that group at some point. So I think our clinical data has been validated by these professional medical device manufacturers. So kind of getting back to your point, there's a little difference between early fundraising and late fundraising, but by the time you get to those late rounds, you've got to have a track record that people can invest in..

Scott Nelson: So you can discuss your experiences dealing with both private venture capital firms as well as corporate venture?

Hugh Narciso: If you interviewed 10 CEOs, you'd get five that fully support corporate partnerships and five that absolutely hate them. Based on my experience, I've had very good relationships with corporate partners and that's both from the medtech world and from pharma. So I think that if you get the right person that is your champion within the company, and they value the indication and the approach that you're taking to deal with that unmet medical need, I think the motivations are all in the right place. I've had the good fortune to work with some great BD people, some great corporate development people, and I can give you an example. When Allergan made their investment, they put a gentleman, David Lawrence, on our board, and David was great. David understands obesity. Obesity can be a nuanced specialty and he really understood the market. He also understood the challenges of operational issues even with a development-stage company. And having that voice kind of balanced out the approach from the venture capitalists. Both were very valuable to BAROnova and I think we had a very functional value-added board to have both the corporate perspective and the venture perspective sitting in the same room.

Scott Nelson: Before we get into the last three questions, let's talk about what's next for BAROnova. You mentioned the pivotal study that you're working on for the US. Talk about that. And then for physicians that are wanting to learn a bit more about the device or are considering ways to treat this patient subset in the future, why should they consider the TPS device.

Hugh Narciso: So we just initiated our U.S. pivotal trial, and I think your audience knows that the pivotal trial is the final trial that you conduct to gain FDA approval. I can't say much about it mostly because it's a double-blinded trial and I don't know much information. I'm blinded to the trial too, but I can tell how it was structured.

As I mentioned, it's a randomized controlled trial. So we've got some patients receiving our device and some patients that receive a sham procedure so they think they have the device. And it was randomized two-to-one - treatment to control group. The goal is to put the device into about 270 patients. So that means 180 will get the device and 90 will be in the control group. And the device will be left in for 1 year. We wanted to differentiate ourselves from some balloon technology, where due to materials, they need to remove the device after about six months. So that's why we're going to leave our device in for one year.

Now, it should be noted that there's nothing in the materials or the mechanics of our device that would prevent it from living in the stomach for two, three, five years. We just need to prove that. And for a startup company to bite off a three-year or a five-year clinical trial right out of the shoot just doesn't make sense. So the plan would be to get the approval at one year of residence time in the patient and then get subsequent approvals to expand that indication out to two years and multiple years after that. But it should also be noted that in this trial, we're treating patients that are 30 to 40 BMI, which is considered a low-BMI clinical trial. That doesn't mean that we couldn't ultimately treat patients that are above 40. What we saw in our Sydney trial was that patients above 40 lost the same percentage of weight as the patients between 30 and 40. So if you're an above 40 BMI patient and you lose 15% of your total weight, you're going to lose a lot more weight than someone who's a 32 BMI. But on a percentage basis, it seems to work the same, independent of BMI.

Now, once we expand north on the BMI scale, there's nothing preventing us from expanding south on the BMI scale for overweight patients. There's a cosmetic indication that we could pursue where people who are overweight and want to lose weight for some specific reason, such as they've got a wedding coming or they want to look good on the beach in the summertime, there's the opportunity to treat those subjects with a shorter-term device. Maybe put it in in January and take it out in April.

There's also the diabetes indication. So people are familiar with weight loss associated with improving your type 2 diabetes. So just by losing weight, you get the secondary effect of improving your diabetic condition by either eliminating the meds you're on or at least reducing the dosage. Well, we think that in addition to the secondary effect of diabetes, we're going to have a primary effect on diabetes. So if you remember early in our conversation, we said that the mechanism that we think we're operating under is slowed gastric emptying. So the food moves from the stomach into the intestine in a slower manner. If you think about that, if the calories are moving from the stomach into the intestine slower, you aren't necessarily changing the amount of glucose that gets released into the bloodstream, but you're doing it over a longer period of time, and when you stretch that time out, the effect is you reduce the glucose peaks. And if you reduce the glucose peaks, that's exactly what you want to do in a diabetic patient. So we think there's a primary effect. There's the potential at least of a primary effect of our device for the diabetic patients, so we're very excited about pursuing a trial in that area once we get our initial approvals.

And lastly, another area we're very excited about is adolescent obesity. There really is nothing for the adolescent obese population right now. You just have to open up the New York Times maybe once a day to see an article on the effects of adolescent obesity. So because our device is completely reversible, you can put it in and take it out, you don't have to worry about the effects of the device on a growing individual; whereas if you were suturing something in place or changing the plumbing like you do with some of the more radical bariatric surgeries, you'd have to worry about that. So, in our case, we can get the effect of our device, remove it, and then the adolescent can move into adulthood and either maintain their weight loss or if they need some intervention, they've got all the options in front of them that they had before.

And so I think all those reasons together make physicians very interested in what we're doing because we can treat a broad band of their population.

Scott Nelson: When hearing you describe how your device functions, it would be the equivalent of why it's more healthy to eat a long-chain carbohydrate because your body digests them slower, preventing those glucose peaks, those insulin peaks, which can be dangerous for diabetic patients. I.

It's one of the reasons I love medtech so much. If put yourself in the shoes of a patient, instead of that patient taking a drug for a prolonged period of time, or maybe in some cases, for the course of their life, they can utilize a device like yours for a temporary period of time.

Hugh Narciso: For obesity, I think that this is really a disease that is best treated with a device as opposed to drugs. What we've seen with the drug studies is not only do you have the effects of a systemic drug on all the systems within the body, but the body habituates to them within the first nine to 12 months. And once the body habituates, it finds another pathway around it and you see that the patient's regained their weight. So I think with a device like ours, where you can leave the device in place for a period of time, get some success, pull the device out. If you fall off the wagon, like I said earlier, you've got all the options in front of you. You can get surgery. You can get another one of our devices. You can get one of the competitive devices put in because you haven't changed anything about your anatomy. You're not all-in like you would be with Roux-en-Y surgery.

Scott Nelson: Ver exciting for BAROnova. Congrats on all the work you guys have done. It's always good to hear some success stories in medtech.

So before we end our conversation, let me ask you a few personal questions. So first, Hugh, what's your favorite non-fiction business book?

Hugh Narciso: Well, I'm a bit of a dinosaur, so my favorite non-fiction business book is an oldie but a goodie. It's Built to Last. It's written by some guys out of Stanford and they did this comparative analysis of a series of competitive company pairs. So they would take two companies within an industry and go through their history and find out why one was more successful than the other one. It's pretty informative on what works and what doesn't work and how you do build something to last.

Scott Nelson: Next question. Is there a business leader, or maybe another founder or CEO that you're following right now? One that really inspires you?

Hugh Narciso: Maybe not necessarily a business leader but I would say closely related. A political leader who inspired me and still inspires me to this day is Ronald Reagan. This was a man with clear, critically-formed ideas, plainly communicated, who had the ability to persuade his opponents to support his policies. It's easy to convince your own troops or people that are on your side to go your way. But a true leader can get people from the other side to hold a view in the same direction. So Reagan's my hero.

Scott Nelson: Good answer. And then lastly, when thinking about your medtech career, what's the one piece of advice that you would tell your 30-year-old self?

Hugh Narciso: If I could talk to my 30-year-old self, I would tell myself go into software development.

Scott Nelson: Nice answer. We'll leave it at that and let the audience sort of take that for what it's worth. But this has been a really enjoyable conversation, Hugh. For people that want to learn more about BAROnova, is it best to direct them to your website?

Hugh Narciso: Yeah, that'd be great, www.BAROnova.com.

Scott Nelson: Again, Hugh, thanks a ton for doing this.

Hugh Narciso: Well, I appreciate the time and I appreciate you reaching out to BAROnova.